Planning Guide for Dementia Care At Home: A Reference Tool for Care Managers

Developed by the Alzheimer's Association - South Central Wisconsin Chapter, Wisconsin Alzheimer's Institute, of the University of Wisconsin - Madison Medical School, and the Wisconsin Bureau of Aging and Long Term Care Resources, Division of Disability and Elder Services, Department of Health and Family Services. 3/2004

Document Number PDE-3195

Planning Guide for Dementia Care at Home: A Reference Tool for Care Managers

Table of Contents:

Planning Guide for Dementia Care at Home: A Reference Tool For Care Managers

Developed Collaboratively by:

Sharon M. Beall B.S.N., M.S.
Past Nurse Consultant,
WI Bureau of Aging & Long Term Care Resources
From 1997 – 2003

Cathy Kehoe B.S.
Alzheimer's Service Developer,
WI Bureau of Aging & Long Term Care Resources

Barbara Lawrence B.S.N., M.S.
Senior Outreach Specialist,
WI Alzheimer's Institute

Mary Reines M.S.W.
Program Director,
Alzheimer's Association South Central Wisconsin

This project was supported, in part, by a grant, number 02-90AZ236901, from the Administration on Aging, Department of Health and Human Services, Washington D.C. 20201.
Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

For an electronic version of this document contact the Wisconsin Department of Health and Family Services, Office on Aging PO Box 7851, Madison, WI, 53707 608-267-2439 e-mail kehoecb@dhfs.state.wi.us or visit the Department's web site - dementia information page: **http://dhfs.wisconsin.gov/aging/Genage/ALZFCGSP.HTM**

Planning Guide for Dementia Care at Home: A Reference Tool for Care Managers

Introduction and Guide

This tool focuses on providing information for planning strategies to support people with Alzheimer's disease and related forms of dementia. Alzheimer's disease causes progressive decline in memory, judgement/decision making ability, language, communication skills and physical function over time. This guide helps to pinpoint and plan for certain hallmarks of decline that signal shifts into the next stage of the illness. The strategies this tool offers are general. Differences in specific problems of the individual and responses to intervention will depend on the types of impairment the individual has, and causes of dementia.

Using the Care Planning Tool:

⇒ **The *Stages of Alzheimer's Disease* reference** on page **iv** can help you to determine the approximate level of function of the person for whom you are planning. Keep in mind that people with Alzheimer's disease can fluctuate from day to day, and may show early stage characteristics while being in mid or late stages in others.

⇒ **Review all stages** for a given care planning area to determine which of the ***Key Assessment Issues*** are reflected in the circumstances of the person with Alzheimer's at this time.

⇒ ***Goals*** signify the optimum condition for the person in that given stage for that given care planning area.

⇒ ***Key Assessment Issues*** are the specific issues the person may experience, in that given stage, for that given care planning area. The issues that you identify will have corresponding ***Possible Interventions*** for each section, which will suggest strategies for creating the optimal ***Goals.***

⇒ **Please note** that the authors' approach to "problem behavior" is that behavior is a symptom which can be addressed by employing preventive or proactive strategies, rather than reactive strategies. Studies show that 80-90 percent of behavioral symptoms can be prevented by modifying the environment, including caregiver skills.

Terms:

ADL	Activities of daily living - such as eating, bathing, dressing, etc.
IADL	Higher levels of ADL's, called Instrumental Activities of Daily Living. These are more are complex such as balancing a checkbook, shopping, etc.
Informal or Natural Supports	People and groups in the person's life which she has been involved with, such as neighbors, friends, relatives, hairdressers, mail carriers, landlords, congregations, etc., who are part of the person's ongoing support.
Goal	The target optimal experience of the person in a respective care planning area in that respective stage of dementia.
Key Assessment Issues	The factors or issues that need to be taken into account during the assessment that may require possible interventions in order to reach the person's goal experience.
Possible Interventions	The possible corresponding actions that could be taken to address the key assessment issues identified. Each issue has one, if not several, interventions.
Palliative Care	Comprehensive and holistic management of a person's end-of-life needs to ensure well-being and relief of pain.
Hospice	A program that provides palliative care. The hospice team develops a plan of care focused on comfort and dignity, not cure or investigation of disease progression, while addressing the emotional, spiritual, psychosocial and symptom management of terminally ill persons.

Sample Case Study Example:

Annie is an 86 year old woman who was diagnosed with Alzheimer's disease five years ago. Annie has been stable while living alone in an apartment complex, due to the help of nearby friends and neighbors who check in with her frequently. Recently her neighbors report that Annie has been yelling at and turning away the people she knows who come to visit. She acts as if they are strangers, and accuses them of wanting to steal from her. Because she is refusing her home delivered meals and disturbing neighbors, Annie's living arrangement may be in jeopardy.

Step 1: Stages of Alzheimer's Disease Reference (page iv)
Annie's behavior symptoms have changed from forgetting details and parts of conversations (Stage 1), to forgetting whom people are (Stage 2). In addition, she is experiencing changes in mood, behavior and personality (Stage 2). It appears that these symptoms have come on rapidly, which may indicate a medical cause.

Step 2: Care Planning Area # 3: Medical Care – Stage 2 (page 3.3)

Goal: The person receives optimal medical care related to diagnosis, treatment and ongoing care
Is Annie receiving ongoing medical care from a physician trained in dementia issues?

Key Assessment Issues: *Could any of her issues be related to her agitation, because of its sudden onset?*

*****Sudden onset of a potentially reversible health problem (infection, illness, etc.)

*Dehydration, constipation, etc.

*Concurrent health condition worsening (e.g., diabetes)

*Inability to report pain being experienced

*Medication issues (forgetting to take, interactions, lowered tolerance, etc.)

*Lack of adequate support for current needs

Possible Interventions:

*****Refer to written information about Annie's health conditions for clues

*Encourage medical evaluation to check for acute health problems (infection, pain, etc.)

*Check to see if medication is being taken as directed, new medications added, multiple doctors prescribing without notifying others, etc.

*Review situation to determine if adequate support is in place for Annie's needs

Step 3: Possible actions taken based on this information:

1. A thorough health screening done by a physician knowledgeable in dementia issues to rule out acute health condition causes
2. Review of concurrent medical conditions, number of medications, number of prescribing physicians and communication between them, and possible medication issues
3. Evaluate level of support against Annie's needs, to determine if adequate
4. Establish a long-range plan for monitoring health issues and supporting needs. Do so in collaboration with caregivers and health professionals, and incorporate the person's current or pre-decided desires
5. Refer to other care planning areas (e.g., environment, psychosocial, etc.) for additional information